Optum

Desk Reference

# Auditors' Desk Reference

A comprehensive resource for code selection and validation



2025

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# Contents





# Chapter 1. **Auditing Processes and Protocols**

Many years ago getting reimbursed for a service was simple, requiring only a handwritten or typed claim form that included the procedure performed, the fee, and the diagnosis. CPT® and ICD-10-CM codes were not necessary. Life was easy. Now the entire process has evolved and everything is much more complicated. Processes have been streamlined, requiring a uniform process for all providers to follow. This chapter discusses some of these processes, and includes information as to why it is necessary to include audits as a part of each practice.

## Claims Reimbursement

Receiving appropriate reimbursement for professional services can sometimes be difficult due to the complexity of rules involved. There are a number of things that are important to consider. The following section discusses some of the various requirements for getting a claim paid promptly and correctly.

### Coverage Issues

Covered services are services payable by the insurer in accordance with the terms of the benefit-plan contract. Such services must be properly documented and medically necessary in order for payment to be made.

Medical necessity has been defined by CMS as "services or supplies that are proper and needed for the diagnosis or treatment of [a] medical condition; are provided for the diagnosis, direct care, and treatment of [a] medical condition; meet the standards of good medical practice in the local area; and aren't mainly for the convenience of [a patient] or doctor."

Section 1862 (a)(1) of the Social Security Act prohibits Medicare from covering items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the function of a malformed body member."

Typically, most payers define medically necessary services or supplies as:

- Services that have been established as safe and effective
- Services that are consistent with the symptoms or diagnosis
- Services that are necessary and consistent with generally accepted medical standards
- Services that are furnished at the most appropriate, safe, and effective level

Documentation must be provided to support the medical necessity of a service, procedure, and/or other item. Remember, payers may request the medical record documentation to determine medical necessity. This documentation should show:

- What service or procedure was rendered
- To what extent the service or procedure was rendered
- Why the service, procedure, or other item was medically warranted

Services, procedures, and/or other items that may not be considered medically necessary are:

- Services that are not typically accepted as safe and effective in the setting where they are provided
- Services that are not generally accepted as safe and effective for the condition being treated
- Services that are not proven to be safe and effective based on peer review or scientific literature
- Experimental or investigational services
- Services that are furnished at a duration, intensity, or frequency that is not medically appropriate
- Services that are not furnished in accordance with accepted standards of medical practice
- Services that are not furnished in a setting appropriate to the patient's medical needs and condition

If a service rendered is not deemed to be medically necessary, that service will be denied. For Medicare, unless the patient was previously notified of this fact and an Advance Beneficiary Notice (ABN, also referred to as a Waiver of Liability Statement) has been completed, the patient may not be billed for these services.


**Denial Alert**

Medical necessity denial decisions must be based on a detailed and thorough analysis of the patient's condition, need for care, safety and effectiveness of the service, and coverage policies.

# Chapter 2. **Focusing and Performing Audits**

Conducting an effective chart audit requires careful planning. A well thought out plan is essential to completing a chart audit that yields useable data.

Some questions to consider before starting the audit are:

- What is the topic/focus of the audit (e.g., evaluation and management, surgery, etc.)?
- Is the topic/focus too narrow or too broad?
- Is there a measure for the topic/focus (e.g., level for established patient visits)?
- Is the measure available in the medical record (e.g., recorded by the provider in review of systems)?
- Has the topic/focus been measured before?
  - If yes, then a benchmark or standard exists.
  - If no, then a standard for comparison may not exist.

Once the answers to the above questions have been determined, the practice must decide which steps are necessary to perform a complete and accurate audit.

## Ten Steps to Audits

**Step 1. Determine who will perform the audit.** An internal audit is typically performed by coding staff within the practice that are proficient in coding and interpreting payer guidelines. Depending upon the size of the practice and the number of services provided annually, a compliance department with full-time auditors may be established. If not, the person performing the audit should not audit claims that he or she completed.

**Step 2. Define the scope of the audit.** Determine what types of services to include in the review. Utilize the most recent Office of Inspector General (OIG) work plan, Recovery Audit Contractor (RAC) issues, and third-party payer provider bulletins, which will help identify areas that can be targeted for upcoming audits. Review the OIG work plan to determine if there are issues of concern that apply to the practice. Determine specific coding issues or claim denials that are experienced by the practice. The frequency and potential effect to reimbursement or potential risk can help prioritize which areas should be reviewed. Services that are frequently performed or have complex coding and billing issues should also be reviewed, as the potential for mistakes or impact to revenue could be substantial.

**Step 3. Determine the type of audit to be performed and the areas to be reviewed.** Once the area of review is identified, careful consideration should be given to the type of audit performed. Reviews can be prospective or retrospective. If a service is new to the practice, or if coding and billing guidelines have recently been revised, it may be advisable to create a policy stating that a prospective review is performed on a specified number of claims as part of a compliance plan. The basic coding audit should include, at minimum, validation of CPT® code use, including the level of E/M visit assigned; undocumented or underdocumented services; correct use of modifiers; and accuracy of diagnosis codes and whether the source document supports medical necessity. Additional areas of review may include verifying that the correct place of service was billed, the correct category of service was billed, and whether there were services documented but not billed.

**Step 4. Request necessary medical record, billing, and reporting documentation.** To verify the accuracy of the services reported, request the patient chart to review the documentation. Also obtain copies of the superbill or charge ticket, along with a copy of the claim form. By examining these documents, problematic areas may be identified, such as data entry errors, use of outdated code sets, incorrect or missing modifier usage, or improperly sequenced surgery CPT codes, which can result in incorrect reimbursement.

**Step 5. Assemble reference materials.** Reference materials, such as current editions of coding manuals, NCCI edits, and CMS or other third-party policies pertinent to the services being reviewed, should be collected. When auditing evaluation and management (E/M) services, determine which set of CMS documentation guidelines are appropriate for the review and have the corresponding E/M audit worksheet available.

> ✓ **Quick Tip**
>
> Keep current with weekly CMS updates by signing up for CMS e-news at https://www.cms.gov/training-education/Medicare-learning-network/newsletter. These notifications are published every Thursday and include Medicare updates and information about CMS national provider calls.

**Step 6. Develop customized data capture tools.** Use an audit worksheet. Audit worksheets (available in the appendix of this book) can aid in the audit process. They help verify that signatures were obtained, that patient identifying information (such as complete name, date of birth) is correct, that the practice is in compliance with "incident-to" guidelines, and that time-based codes are documented and reported appropriately.



# Chapter 3. **Modifiers**

Over the last 20 years, physicians and hospitals have learned that coding and billing are closely connected processes. Coding provides the universal language through which providers and hospitals can communicate—or bill—their services to third-party payers, including managed care organizations, the federal Medicare program, and state Medicaid programs.

The use of modifiers is an important part of coding and billing for health care services. Modifier use has increased as various commercial payers, who in the past did not incorporate modifiers into their reimbursement protocol, recognize and accept HCPCS codes appended with these specialized billing flags.

Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers. With that being said, modifier use should also be incorporated into a practice's audit plan.

## What is a modifier?

A modifier is a two-digit numeric alpha or alphanumeric code appended to a CPT® or HCPCS code to indicate that a service or procedure has been altered by some special circumstance, but for which the basic code description itself has not changed. A modifier can also indicate that an administrative requirement, such as completion of a waiver of liability statement, has been performed. Both the CPT and HCPCS Level II coding systems contain modifiers.

The CPT code book, *CPT 2024,* lists the following examples of when a modifier may be appropriate (this list does not include all of the applications for modifiers).

- A service or procedure has both a professional and technical component, but both components are not applicable.
- A service or procedure was performed by more than one physician or other health care professional and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was performed more than once.
- Unusual events occurred.
- The physical status of a patient for the administration of anesthesia must be defined.

Modifiers from either level may be applied to a procedure code. In other words, a CPT or HCPCS Level II modifier may be applied to a CPT or HCPCS Level II code.

## Types of Modifiers

There are basically two types of modifiers: informational modifiers (those that do not affect payment) and payment modifiers (modifiers that affect reimbursement).

### Informational Modifiers

Although informational modifiers may not have a direct impact on reimbursement, it should be noted that the improper use of an informational modifier may affect coverage of a service or procedure. Failure to use or to apply informational modifiers correctly may result in claim denial or can affect balance billing.

For example, a patient receives a service that is unlikely to be covered by Medicare. The office fails to complete an advance beneficiary notice (ABN); however, the claim is submitted with modifier GA Waiver of liability statement on file, appended to the procedure code. The Medicare contractor contacts the office and requests that the completed waiver be faxed as proof that it was obtained.

Since the office cannot comply, the service is denied and the Medicare remittance advice (RA) indicates that the patient cannot be billed for the noncovered service.

### Payment Modifiers

Other modifiers have a direct impact on the amount a provider may be paid for a service or procedure. For example, a physician provides only the postoperative care following a laparoscopic cholecystectomy. In this instance, CPT code 47562 Laparoscopy, surgical; cholecystectomy, is submitted with modifier 55 Postoperative management only, appended to the code. The payer reimburses the physician the postoperative care portion of the procedure fee only.



## Using Modifiers

There are two levels of modifiers within the HCPCS coding system. Level I (CPT) and Level II (HCPCS Level II) modifiers are applicable nationally for many third-party payers and all Medicare Part B claims. Level I or CPT modifiers are developed by the American Medical Association (AMA). HCPCS Level II modifiers are developed by the Centers for Medicare and Medicaid Services (CMS).

The Health Insurance Portability and Accountability Act (HIPAA) guidelines indicate that all codes and modifiers are to be standardized. Some coding and modifier information issued by CMS differs from the AMA's coding advice in the CPT book; a clear understanding of each payer's rules is necessary to assign such modifiers correctly.

Generally speaking, modifiers are specific to certain sections of the CPT book. The following table contains a list of CPT modifiers and the CPT section to which they can be applied.

## CPT Modifiers and Applicable Sections

### Table 1

| Modifier | Brief Description | Applicable Sections |
|---|---|---|
| 22 | Increased procedural services | Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 23 | Unusual anesthesia | Anesthesia |
| 24 | Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period | E/M |
| 25 | Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service | E/M |
| 26 | Professional component | Surgery, Radiology, Pathology and Laboratory, Medicine |
| 32 | Mandated services | E/M, Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 33 | Preventive service | E/M, Surgery, Radiology, Pathology & Laboratory, Medicine (Services rated "A" or "B" by the USPSTF, Preventive care and screenings) |
| 47 | Anesthesia by surgeon | Surgery |
| 50 | Bilateral procedure | Surgery, Radiology, Medicine |
| 51 | Multiple procedures | Anesthesia, Surgery, Radiology, Medicine |
| 52 | Reduced services | Surgery, Radiology, Pathology and Laboratory, Medicine |
| 53 | Discontinued procedure | Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 54 | Surgical care only | Surgery |
| 55 | Postoperative management only | Surgery, Medicine |
| 56 | Preoperative management only | Surgery, Medicine |
| 57 | Decision for surgery | E/M, Medicine |
| 58 | Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period | Surgery, Radiology, Medicine |
| 59 | Distinct procedural service | Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 62 | Two surgeons | Surgery |
| 63 | Procedure performed on infants less than 4kg | Surgery |
| 66 | Surgical team | Surgery |

# Chapter 4. **Auditing Evaluation and Management Services**

## Evaluation and Management Codes

To make certain that evaluation and management (E/M) coding is reported correctly, it is essential to document the complete clinical picture in the medical record. Higher levels of service require more advanced documentation that supports not only the components of E/M codes but also the medical necessity of a higher level of service. In spite of years of examination and refining, E/M claims reviews remain a subjective endeavor. In simulated situations where documentation is borderline, justification to downcode the claim is as likely to be based on the time of day as it is the complexity of the medical decision. To be fair, recent studies show wide discrepancies when the same documentation was submitted to professional coders for code assignment as well.

From a coder's perspective, one of the most difficult instincts to curb is the desire to fill in missing information in the medical record to justify a code selection that seems intuitively or historically correct. As an auditor, determining that the documentation meets or exceeds the components of the E/M code is imperative. Clearly, coders and auditors can never fill in, extrapolate, or assume that elements belong in the medical records that, in fact, do not appear there. If the documentation does not meet or exceed the specified requirements for coding and reimbursement purposes, it should be viewed as if it was not performed. Each E/M service is evaluated on the documentation for that service only; referring to information obtained from a prior encounter is unacceptable grounds upon which to make a code assignment.

As a result of these discrepancies and difficulties, E/M coding has ushered in an era of greater provider involvement in the coding process and increased clinical and technical demands on coding professionals.

Because evaluation and management (E/M) codes represent the most frequently reported services and comprise 70 to 80 percent of all billed services, they are the target of many payer audits and are also cited in the Office of the Inspector General (OIG) work plan regularly. This chapter contains an overview of E/M services and includes guidance for auditing provider services.

## E/M Levels of Service

The levels of E/M services define the wide variations in skill, effort, time, and medical knowledge required for preventing or diagnosing and treating illness or injury. They also include services promoting optimal health and prevention of health conditions. These codes are intended to denote provider work, including cognitive work. Because much of this work revolves around the thought process of the provider, and involves a large amount of provider training, experience, expertise, and knowledge, the true indications of the level of work may be difficult to recognize without some explanation.

> **Auditor's Alert**
> Each E/M category and section has guidelines specific to that type of service. Read the guidelines before each category in the CPT book to determine the most appropriate code for the service performed.

E/M services are in broad categories and subcategories. The following guidelines apply to categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Service
- Prolonged Services With or Without Direct Patient Contact on the Date of an Evaluation and Management Service



# Skin Lesion Removal: Shaving (11300–11313)

These codes are used to report the sharp removal of epidermal or dermal lesions by a transverse or horizontal slicing method (shaving).

## Procedure Differentiation

Appropriate code selection is determined by the location and size of the lesion. Shaving is a method of removal that would not require a suture closure. The codes include chemical or electrocauterization. When measuring the size of the lesion, the borders around the area are not considered part of the lesion diameter.

## Medical Necessity

The following conditions may warrant these procedures (this list is not all inclusive):

- Actinic keratosis
- Inflamed seborrheic keratosis
- Molluscum contagiosum
- Viral and plantar warts

### Definitions

**actinic keratosis.** Flat, scaly precancerous lesions appearing on dry, sun-aged, and overexposed skin, including the eyelids.

**seborrheic keratosis.** Common, benign, noninvasive, lightly pigmented, warty growth composed of basaloid cells that usually appear at middle age as soft, easily crumbling plaques on the face, trunk, and extremities.

## Key Documentation Terms

Terms such as dermal, epidermal, and shaving provide the guidance needed to ensure correct code assignment. Documentation for these procedures must indicate that the provider removed a single, elevated epidermal or dermal lesion by placing a scalpel blade against the skin, adjacent to the lesion, and, using a horizontal slicing motion, excised the lesion from its base. When a lesion is removed by this method, the wound does not require suturing and bleeding is controlled by chemical or electrical cauterization. Correct reporting of the procedure involves knowing the size and anatomical location of the lesion.

## Coding Tips

- The removal of skin tags by shaving should not be reported with a code from this range, see 11200–11201.
- Chemical or electrical cauterization of the wound is included in these services.
- If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

## Coding Traps

- Per *CPT Assistant*, intent should be considered. If the intent of a shave biopsy or shave removal is to obtain tissue for pathological examination for diagnostic purposes, report biopsy codes 11102–11107 instead of 11300–11313. Documentation should include the diagnostic intent with indications such as a changing or bleeding lesion or an atypical nevus.
- Codes 11300–11313 are reported when shave removal is performed for therapeutic intent such as a lesion that rubs on a waistband or gets in the way when shaving. These may be submitted to pathology as an automatic process per office guidelines, but this does not mean that the intent was diagnostic.

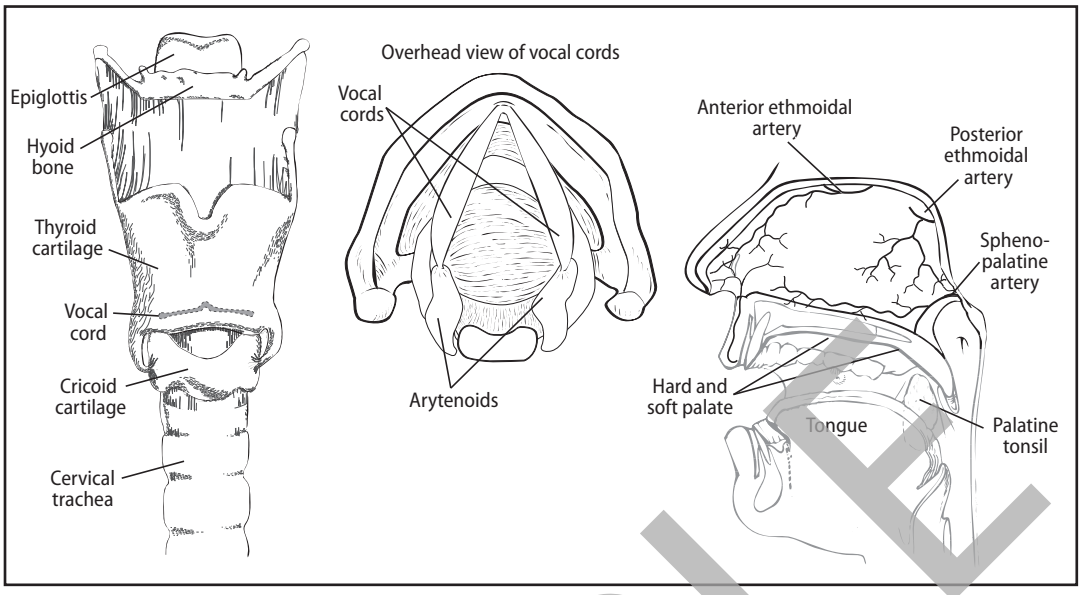
# Skin Lesion Removal (11400–11646)

Codes for the excision of skin lesions include:

- Biopsy of same lesion
- Full-thickness removal including margins
- Lesion measurement before excision at largest diameter plus margin
- Local anesthesia
- Simple, nonlayered closure

Measurements must be precise because being off by just one millimeter can result in the selection of an incorrect code. When more than one dimension of a lesion is provided, indicate the largest side. For example, if the dimensions are described as 2 x 1.2 x 0.5 cm, the lesion should be listed as 2 cm.

# Endoscopy of the Larynx (31505–31579)




Very simply, a laryngoscopy visualizes the interior of the tongue base, larynx, and hypopharynx; it can be done for diagnostic purposes or surgical purposes. Within the structures examined, there are midline (single anatomic sites) and paired structures. When reporting procedures, if one side of a paired structure is involved then a unilateral code is reported. The structures are identified below.

| Midline | Paired |
|---|---|
| Epiglottis | Arytenoids |
| Posterior pharyngeal wall | Aryepiglottic folds |
| Subglottis | False vocal cords |
| Tongue base | Pyriform sinuses |
| Vallecula | True vocal cords |
| | Ventricles |

There are different approaches that may be used, including indirect, direct, and direct operative. Each is explained briefly below.

## Procedure Differentiation

An indirect laryngoscopy involves the visualization of the larynx using a warm laryngeal mirror positioned at the back of the throat and a head mirror held in front of the mouth containing a light source. This method should be attempted prior to considering a flexible or rigid laryngoscopy.

Direct laryngoscopy involves the visualization of the tongue base, larynx, and hypopharynx by passing a rigid or flexible fiberoptic endoscope through the mouth and pharynx to the larynx. If the laryngoscopy was direct, ascertain whether the procedure was performed with an operating microscope (microsurgery), telescope, or flexible fiberoptic scope. A flexible laryngoscopy is often used when gagging limits the mirror used in an indirect exam, as well as to obtain a more clear view of laryngeal structures when the diagnostic need arises.

Operative direct laryngoscopy involves an examination of the tongue base, larynx, and hypopharynx by the passing of a rigid or fiberoptic endoscope through the mouth and pharynx to the larynx with the patient under general anesthesia.

Separate endoscopic codes are provided for direct and indirect procedures; procedures on newborns; and diagnostic, biopsy, foreign body removal, and injection procedures. Review each code description carefully and review the provider's documentation before assigning the code.

# Chapter 7. **Auditing Radiology Services**

Radiology services have unique components that make coding, billing, and auditing more complex than other services. Some of the unique components include:

- Radiology services consist of two components: the technical and professional component.
- Radiology services may be diagnostic, therapeutic, or interventional.
- Radiology services can be performed in a variety of settings and by more than one provider.

When auditing radiology services, the auditor must determine:

- What service was provided?
- Where was the service performed?
- Who owns the equipment used to perform the service?
- Did the provider perform both the technical and professional components?
- Was more than one procedure performed?
- Are the procedures within the same family and, therefore, should the multiple procedure reduction apply?
- How many providers performed the service, and if more than one, who did what?
- Why was the service performed?
- Was the service for screening purposes?

> **Auditor's Alert**
> See appendix 1 for the audit worksheet for radiology procedures.

The CPT® book provides guidelines for radiology codes at the beginning of the radiology section. Notes providing additional instruction may also be found at the beginning of many subsections. Additional instruction is also provided at the code categories or subcategories level, as well as parenthetical notes specific to a code or group of codes.

## Date of Service

When auditing radiology services, the date of service in the medical record should be compared to the date of service on the claim and any discrepancies should be noted.

## Medical Necessity

The medical necessity of radiology procedures must be supported by the reason the service was rendered. However, unlike surgical or evaluation and management services, the medical necessity of the service may be established by the provider who orders the service. For example, a patient presents to his or her primary care physician complaining of a cough. The primary care physician orders a chest x-ray from the radiology group located in the same medical building. On the request for the service, the primary care physician should indicate the reason the service is being ordered.

When completing the claim form, ICD-10-CM coding guidelines indicate that the radiologist should identify the reason the service was requested unless another definitive diagnosis was established as a result of the service. In other words, if after interpreting the chest x-ray in the scenario above the radiologist notes that the patient has pneumonia, the diagnosis reported should be pneumonia.

There will be times, however, that the request does not contain a reason for the service. In this instance, the medical record should include documentation that the requesting provider was contacted, and that a reason for the service was provided. Additionally, there may be times when the radiology practice may contact the referring provider to obtain additional information regarding the patient's condition to further substantiate the medical necessity of the service. This, too, should be well documented.

Medical record documentation must also necessitate the need for certain screening services. When a service such as a screening mammography is performed, it is imperative that the claim indicates the appropriate Z code to identify the screening nature of the service. Failure to do so can result in claim denial, inappropriate payment, or inappropriate costs to the patient.



# Chapter 8. **Auditing Pathology and Laboratory Procedures**

The pathology and laboratory CPT® codes (80047–89398 and 0001U–0438U) are used for those services provided by a reference, hospital, or physician laboratory. **Note:** A draw station is not a laboratory. It is a place where a specimen is collected but no laboratory testing is performed on the specimen.

## Laboratory and Pathology Coding and Billing Considerations

A laboratory is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, and treatment of disease or impairment, or assessment of health. A diagnostic laboratory test is considered a laboratory service for billing purposes, regardless of where it is performed.

Some factors that can influence billing and payment of laboratory services include:

- Clinical Laboratory Improvement Amendment (CLIA) status
- Point of service
- Billing authority
- Code selection
- Modifier assignment
- Units of service
- Qualifying circumstances

> **Auditor's Alert**
> See appendix 1 for the audit worksheet for laboratory procedures.

### Clinical Laboratory Improvement Amendments Status

CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). The objective of the CLIA program is to ensure quality laboratory testing. All clinical laboratories must enroll in CLIA and they must be certified to test in order to receive Medicare or Medicaid payments. The type of certification is dependent upon the complexity of the test being performed. There are three basic levels of CLIA tests: waived, moderate, and high-complexity. Each level of complexity has a set of personnel requirements, as well as proficiency standards that must be met in order for that entity to be certified. This information can be found on the Center for Disease Control website at http://www.cdc.gov/CLIA/default.aspx. CLIA certified laboratories are able to bill for laboratory procedures that fall within their certification level. The CLIA number must be entered on the claim as a condition for payment. Medicare contractors deny claims for diagnostic clinical laboratory tests performed if the laboratory CLIA certificate is expired or the laboratory performs a testing outside the scope of their certificate.

There are five types of certification that a laboratory can receive:

- **Certificate of Waiver:** Permits the laboratory or physician practice to perform only waived tests. Waived tests have been deemed simple and accurate and have little risk of error. Examples of waived tests include fecal occult blood tests and some types of urinalysis. A list of CLIA waived tests can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files. The columns are broken down as follows:

| | |
|---|---|
| Column 1 | Year: Calendar year rates are effective. |
| Column 2 | Code: Active CPT and HCPCS Level II codes for laboratory services. |
| Column 3 | Modifier: When included, QW denotes a CLIA-waived test (with the exception of codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651, which do not require modifier QW to be recognized as a waived test). |
| Column 4 | Effective Date: Date fee schedule rates are effective. |
| Column 5 | Indicator: This indicates if the service is paid at the national level (N) or by the local contractor (L). |
| Column 6 | Rate: Payment rate shown by the dollar amount. |
| Column 7 | Description: Short description of the service. |
| Column 8 | Description: Long description of the service. |
| Column 9 | Description: Extended long description of the service. |



- As add-on codes, 90461, 90472, and 90474 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same provider on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. The following table provides additional information for these codes as found in the Medicare Physician Fee Schedule Database.

| Parent Code | Add-On | GLOB DAYS | MULT PROC | BILAT SURG | ASST SURG | COSURG | TEAM SURG |
|---|---|---|---|---|---|---|---|
| **90460** | | XXX | 0 | 0 | 0 | 0 | 0 |
| | **90461** | ZZZ | 0 | 0 | 0 | 0 | 0 |
| **90471** | | XXX | 0 | 0 | 0 | 0 | 0 |
| | **90472** | ZZZ | 0 | 0 | 0 | 0 | 0 |
| **90473** | | XXX | 0 | 0 | 0 | 0 | 0 |
| | **90474** | ZZZ | 0 | 0 | 0 | 0 | 0 |

# Coronavirus Disease COVID-19

On November 1, 2024, almost all codes for COVID-19 vaccine products and administration were deleted. Five new product codes and a new administration code were released on August 14, 2024. These changes were made in an effort to streamline COVID-19 vaccine codes for easier reporting.

Code 90480 replaces all other COVID-19 vaccine administration codes. This single administration code should be reported for administration of all COVID-19 vaccine products for children and adults. Counseling is included in this service and is not reported separately.

Codes 91318, 91319, and 91320 represent vaccine products from Pfizer; 91321 and 91322 are for vaccine products from Moderna. The code descriptions vary by dosage amounts for different age ranges. Existing code 91304 has been revised to remove the term "preservative free" and can be reported for the Novavax vaccine.

The current COVID-19 vaccines and administration codes are as follows:

| CPT | Description | Manufacturer | Age |
|---|---|---|---|
| **90480** | Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose | Any | Any |
| **91304** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use | Novavax | 12 years and older |
| **91318** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use | Pfizer | 6 months–4 years |
| **91319** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use | Pfizer | 5 years–11 years |
| **91320** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use | Pfizer | 12 years and older |
| **91321** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use | Moderna | 6 months–11 years |
| **91322** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use | Moderna | 12 years and older |




## Auditor's Alert

The COVID-19 vaccine revisions will not be reflected in the AMA's 2024 CPT book as the publication was already finalized when these decisions were made by the CPT Editorial panel. For current and historical COVID-19 vaccine coding guidance, see https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes.



# Appendix 1. **Audit Worksheets**

**Electronic Copies of Auditing Worksheets**

This edition of the *Auditors' Desk Reference* includes access to formatted copies of the auditing worksheets found in this manual. To access these worksheets go to this address: https://www.optumcoding.com/support/product-update/?updateid=optumAUDR24/. Please use the following password to access updates: optumAUDR24

Customers are permitted to reproduce these worksheets for use within their own facility or medical practice. Wider licensing of this content is available. Other distribution is prohibited.

These audit worksheets can be used when auditing the different areas of CPT® codes.

## Modifier Worksheet

The following worksheet may be used to collect the necessary data when auditing a medical record for modifier use.

Account/medical record number: _____ Date of service: _____

Reviewer: _____ Date of review: _____

Type of review: _____

**Documentation**

| | Supports Modifier Assignment | | Provides Necessary Detail | | Authenticated | | Comments |
|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | |
| Modifier | | | | | | | |
| Modifier | | | | | | | |
| Modifier | | | | | | | |

**Assignment**

| | Correct Modifier Assigned | | Appended to Correct Code | | Valid for Procedure | | Guidelines Applied | | No Code Describing Service | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | |
| Modifier | | | | | | | | | | | |
| Modifier | | | | | | | | | | | |
| Modifier | | | | | | | | | | | |

**Reimbursement**

| | Fee Revisions Made | | Comments |
|---|---|---|---|
| | Yes | No | |
| Modifier | | | |
| Modifier | | | |
| Modifier | | | |

**Payer Issues**

| | Modifier Processed | | Payment Adjustment Made Correctly | | Prevent Denial | | Comments |
|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | |
| Modifier | | | | | | | |
| Modifier | | | | | | | |
| Modifier | | | | | | | |

**Claim Issues**

| | Indicated on Claim Correctly | | Claim Attachments Submitted | | | Payer Inquiries Responded To | | | Comments |
|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | N/A | Yes | No | N/A | |
| Modifier | | | | | | | | | |
| Modifier | | | | | | | | | |
| Modifier | | | | | | | | | |